Case Management
Intake Form

THSteps MCM ☐ TCM/PWI ☐ CSHCN ☐ FACE to FACE ☐ TELEPHONE ☐

Client Demographics												
Date of Referral:		Date of Intake:		Title V Client:	Yes ____ No ___							
Last Name:			First Name:			M.I.:						
Date of Birth:		Sex:	M ___ F ____		SSN:							
Medicaid #:		Managed Care Plan:	Yes ____ No ___		Plan Name:							
Parent/ Guardian:			Home Phone:		Work Phone:							
Street Address:			City:									
Zip Code:		County:		Migrant Family:	Yes ____ No ____							
Mailing Address:		City:		Zip Code:								
Directions to Home:												
Additional Contact:												
Language Preference:			Interpreter Needed:	Yes ____ No ____								
Primary Care Physician:		Address:										
Referral Source:		Address:										

Health Condition/Health Risk (may be psychosocial risk for PWI clients):	
Primary:	
Secondary:	
Additional:	

Need for Case Management:

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Client Choice and Eligibility			
Has Client Been Made Aware of Choice of Case Management Providers:			Yes ____ No ____
Does Client Desire Case Management Services:			Yes ____ No ____
Is Client Currently Receiving Case Management Services from another MCM or PWI Provider:			Yes ____ No ____
Has Client Received Case Management Services from another MCM or PWI provider in the past 12 months:			Yes ____ No ____
Is Client Receiving Case Management Services from MHMR, ECI, TCB or Another State Agency:			Yes ____ No ____
Name of Other Case Management Provider:		Name of Other Case Manager:	
Is Client Eligible for and to be Enrolled in THSteps MCM:			Yes ____ No ____
Is Client Eligible for and to be Enrolled in TCM/PWI:			Yes ____ No ____
If Client is Not Eligible for Either MCM or TCM/PWI, Provide Reason:	☐ Client Refuses Services ☐ Currently Receiving Medicaid Case Management Services ☐ Requires THSteps Outreach and Informing Only ☐ Requires Medical Transportation Services Only ☐ Other _____		
If Client Not Enrolled for Services, Alternative Referrals Provided:			

☐ THSteps Medicaid Complaint Number Give to Client

_____ _____

Case Manager Signature Date

_____ _____

Case Manager Name (please print) Case Management Provider and Provider Number (please print)

Date Intake Form Mailed/Faxed to TDH Regional Office:	

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FOR USE BY TDH Regional Office

Date Received by TDH:		TDH Staff:	
Date Checked for Duplication:		TDH Staff:	
Date input in Client Data Base:		TDH Staff:	

Client's Name: _____